

# Working with Chronically Homeless People

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The logo for the Center for Urban Community Services (CUCS) features the acronym "CUCS" in white, bold, sans-serif capital letters. The text is positioned on a dark red, parallelogram-shaped background that is tilted slightly to the right.

CUCS

center for urban  
community services

*Rebuilding Lives, Sharing Knowledge, Shaping Systems*

# CENTER FOR URBAN COMMUNITY SERVICES

CUCS offers a range of programs & services to more than 25,000 individuals and families in NYC.

- |                        |                              |             |
|------------------------|------------------------------|-------------|
| ▪ Permanent Housing    | Transitional Housing         | Single Stop |
| ▪ Street Outreach      | ACT Team                     | PPOH        |
| ▪ Housing Consultation | Case Management Consultation |             |

CUCS shares knowledge with several thousand direct care staff annually through Training & Consulting Services.

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| ▪ Training | Consultation |
|------------|--------------|

# Housing Innovations

Housing Innovations (HI) is a consulting and training firm focusing on solutions to ending homelessness. Its principals have been providing consulting and training services on innovative housing and services strategies to organizations for over 30 years. HI's work is grounded in practice as all of the principals have direct experience developing and/or operating housing and services programs and implementing systems changes.

www. [housinginnovations.us](http://housinginnovations.us)



# AGENDA

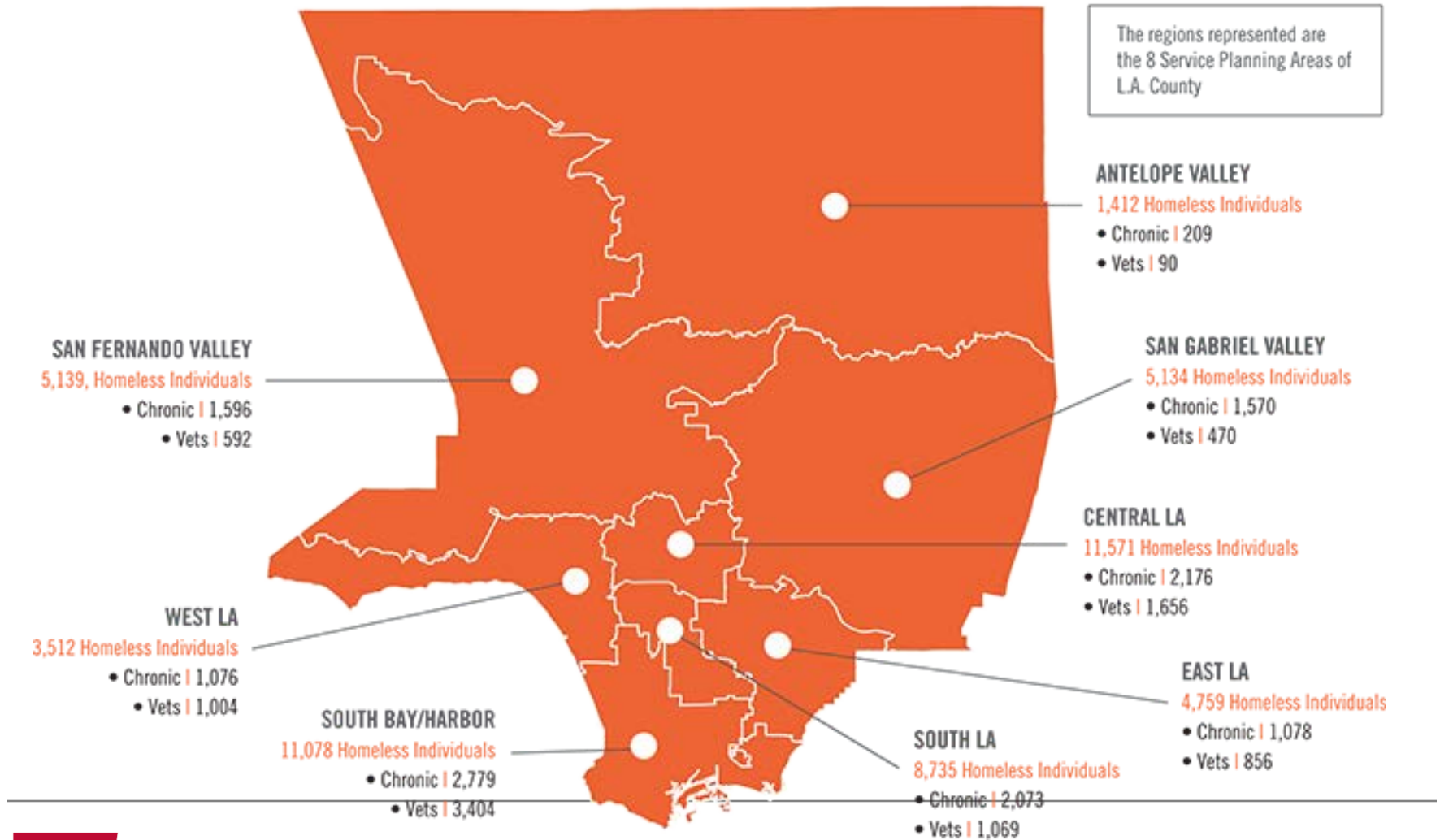
- Chronic Homelessness: An Overview of Definitions and Data
- Engagement Strategies
- Assessment & Interventions for Housing Stabilization
- Evidence-based Practices
- Resources

# Homelessness in LA: The Data

# HOMELESSNESS IN LA COUNTY (LAHSA 2011 Report)

- As of 2011, LA County had an estimated 51,340 homeless individuals and families, 60% of them unsheltered
- 79% are single adults, 20% are families and 1% are unaccompanied youth
  - 33% have a mental illness
  - 34% have substance use issues
  - 22% have a physical disability
- Over 11,000 are Chronically Homeless

# HOMELESSNESS IN LA County



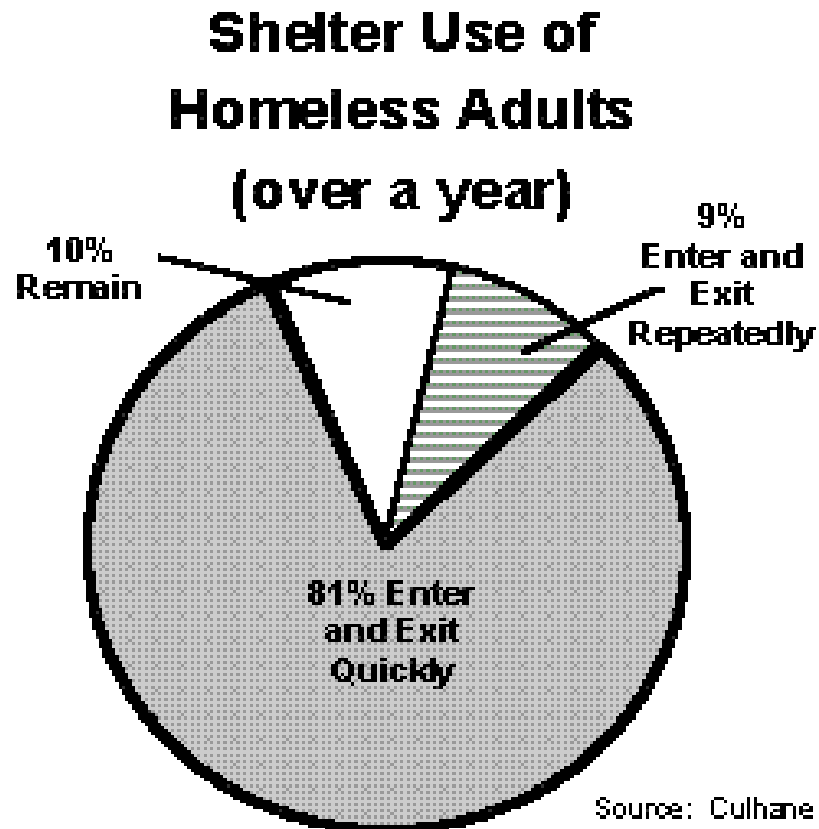
# Overview of Chronic Homelessness



# HUD DEFINES CHRONIC HOMELESSNESS AS:

- 1) An individual who is homeless AND
  - I. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; AND
  - II. has been homeless for at least 1 year or on at least 4 separate occasions in the last 3 years; AND
  - III. has substance abuse disorder, serious mental illness, developmental disability, PTSD, TBI or chronic physical illness or disability
- 2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health facility or other similar facility for fewer than 90 days and was chronically homeless before entering that facility OR
- 3) A family with an adult head of household who is chronically homeless (or if there is no adult in the family, a minor head of household) who is chronically homeless, including a family whose composition has fluctuated while the head of household has been homeless

# WHAT DOES THE PIE CHART REVEAL?



# CHRONIC HOMELESSNESS NATIONALLY

- Chronic homelessness has been decreasing in the last several years
  - 2011: 107,148
  - 2012: 99,894

# WHY TARGET CHRONICALLY HOMELESS PEOPLE?

- A small group of chronically homeless individuals (10%-20%) use 50% of the homeless resources.
- Reducing chronic homelessness frees up resources for the rest of the homeless population
- Substantial public cost incurred by various systems, e.g. emergency rooms, jails/prisons, shelter beds, and other institutions
- The cost of *not* offering housing and supportive services is basically equal to the cost of providing supportive housing; although the latter is more humane and better overall for society

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■ People can succeed in housing

# HOME 4 GOOD STANDARDS OF EXCELLENCE

Focus on access to housing and income and housing retention

Standards for outreach, shelter and housing providers

Target services to people who are chronically homeless

Direct services to meet individual needs

# Engagement Strategies

When you think about  
“chronically homeless” what  
things come to mind?

# POSSIBLE ANSWERS

- have “trust” issues
- poor coping skills
- actively using drugs or alcohol
- untreated mental health issues
- will be very difficult to house
- What are others?



# THE HOMELESS EXPERIENCE

Homeless people risk losing everything that made the world a safe, predictable, and ordered place.

- simple things become difficult  
e.g. taking a shower, feeding yourself
- lack of sleep
- loss of social role
- loss of structure/daily routine
- loss of control over their lives
- waiting in lines
- lack of privacy
- dependent on others
- compromised health



# ADAPTIVE SKILLS

- fly under the radar
- resistance to change
- ingratiating to workers
- hyper-dependence or the flipside: lack of trust
- passivity
- toughness or threatening behavior to avoid being victimized
- disruptive behavior to get transfer or attention (i.e., starting an altercation to attract a worker's attention)
- hyper-vigilance/anxiety
- avoidance: leaving during the day because required to and to avoid the setting

# TRAUMA

- often part of a person's history
- homelessness is both a cause & consequence of trauma
- has significant and long term impact
- often surrounded by painful thoughts, shame and self-blame
- symptoms are often mis-diagnosed

# GRAVITATION TOWARDS THE FAMILIAR



# “GRAVITATION TOWARDS THE FAMILIAR”

- being homeless becomes their identity; this is who they are
- mastery at being homeless; inept at not being homeless
- difficulty with structured environments e.g. housing
- state of homelessness is an important source of self-esteem and personal identity
- attached to the freedom of living on the streets
- life on the streets is one of the few things within their control
- conscious desire of wanting their homelessness to end; unconscious feelings of needing to stay homeless
- ambivalence of feeling free coupled with the uncomfortable feelings of anxiety within a structured setting is a powerful force that can be difficult to counter

# WHY INDIVIDUALS MAY REJECT OUR HELP

- bad experiences with social services
- broken promises
- symptoms are difficult to treat (e.g. negative symptoms of schizophrenia)
- treatment has failed (medication, detox, therapy)
- past traumatic experiences are painful to discuss
- fear of finding out more bad news (e.g. going to the doctor)

# EMOTIONAL RESPONSES TO MOVING INTO HOUSING

- anxiousness and/or fear about the change
- anger/sadness over leaving known setting and staff
- worried about failing
- frustrated that it is not exactly how they planned it would be
- elated about obtaining their own place
- ambivalence about such a big change in their lives
- stress over entering a new stage of their life

# Service Strategies That Work



# ENGAGEMENT

Engagement: a **process** of **building** a **personal connection** that may play a role in helping a person improve his/her health status, housing situation, social support network, or life in general

The first contact with a client is **critical and** loaded with possibility.

How can we make the most of these possibilities?

# ENGAGEMENT

What is often the client's agenda when meeting with us?

What is ours?

*They are often different!*

How can we align our agendas?

What factors might influence a client's agenda?

- history with mental health services
- has felt infantilized in past
- sees no need for help
- history of trauma
- symptoms of illness

# TIPS FOR PERSON-CENTERED ENGAGEMENT

How can we be person centered in these kind of situations?

- be respectful; **be genuine**
- let the client be in control in any way possible
- roll with resistance (Motivational Interviewing Strategy)
- include as many of the client's personal preferences/priorities as possible
- **acknowledge any inconvenience your request may cause**
- acknowledge their side of the situation

# STRATEGIES THAT WORK

What has worked for you?

- communicate your role clearly
- find common ground (focus on personal goals)
- instill hope accept denial and resistance, give credit for surviving, acknowledge past bad experiences
- respond to “felt needs”
- address mental health treatment issues
- do not deny or agree with delusions
- focus on coping and decision making skills and communication skills

# APPROACHES THAT WORK

- **Keep it light**

- Talk about what the client wants to talk about
- Respect the client's boundaries about what they do and do not prefer to share
- What does the client want? Services? Something else?
- Reach out frequently and creatively

- **Keep encounters brief and low demand**

- Work to understand how the person sees their situation; talk about what they care about

- 
- Provide information on their interests... such as?

# MORE TIPS

- be persistent and consistent; follow up
- allow rescheduling
- offer choices
- respect clients' autonomy
- affirm the client's right to self-determination
- enter into a partnership with clients - how can you work together toward a goal?
- honor client' expertise, experience and ideas
- focus on exploring clients' ideas and concerns

# BODY LANGUAGE

research varies but it is generally understood that anywhere from 70 to over 90% of communication is non-verbal.

remember: it's not just what we say, it's also how we say it!

# Assessment & Planning

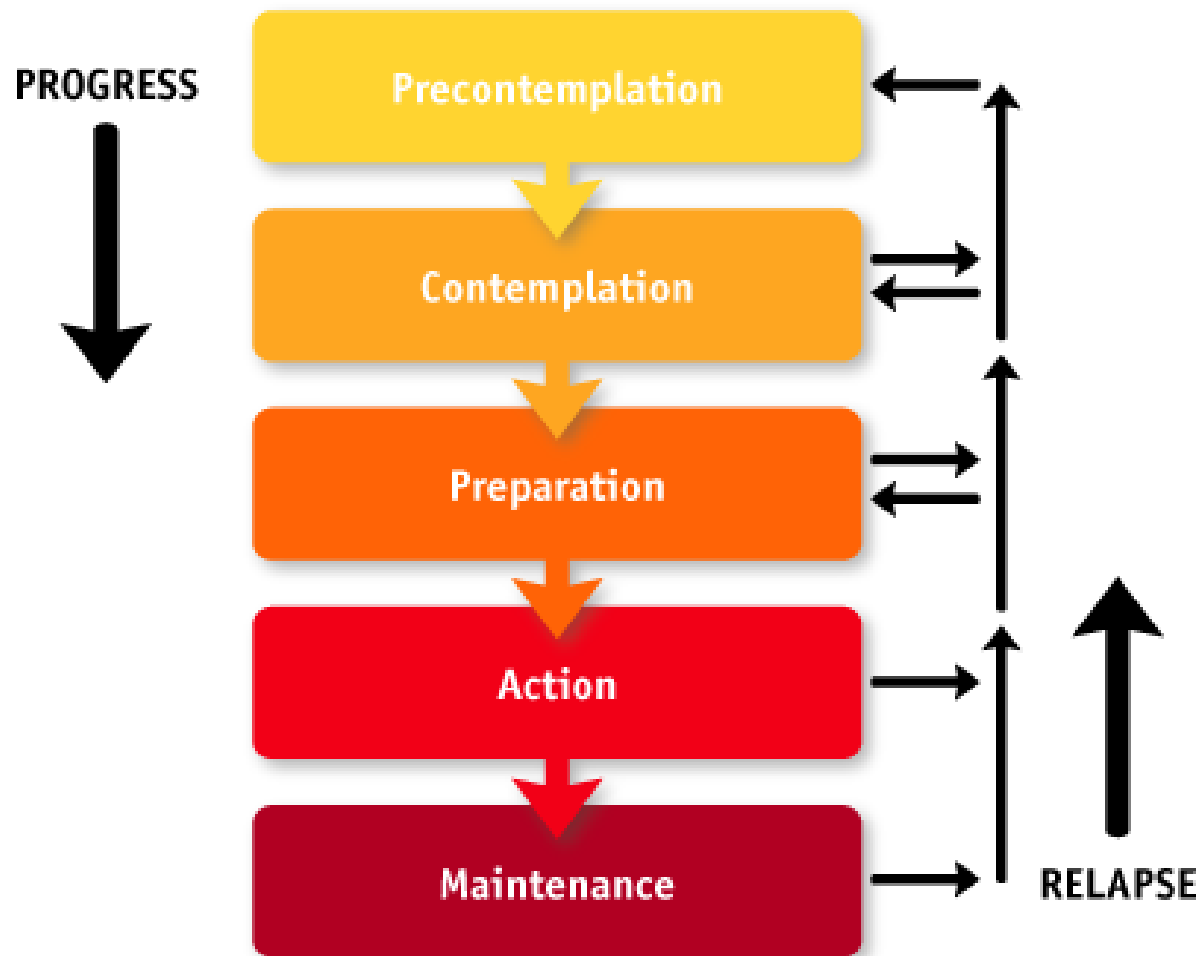


# ASSESSMENT

## Conduct Ongoing Assessments

- it is often difficult and takes longer to get a clear picture of the person and what s/he needs
- allow more time for the assessment process
- use the stages of change to identify appropriate interventions
- continue assessment over time

# STAGES OF CHANGE



# ASSESSMENT DOMAINS - HOUSING

1. Housing and Homelessness History
2. Income and Financial Management
3. Family & Other Relationships
4. Mental Health, Medical, Substance Use - issues and response to treatment
5. Life Skills
6. Strengths and Potential for Change - how has person managed in the past?
7. Future Goals

# Access to Housing

## Engagement

Risk Assessment: assess for any crisis situations

Educate person about Housing Options they may be eligible for

Provide direct services and assistance to link with resources as needed

- May include income, ID, and other concrete needs to access housing
- Addressing immediate needs
- May be linkages to needed care Housing Assessment

# Housing Stabilization Services

## Assessment

- Understanding Housing Goals and Barriers

Engagement on Goals - what does the person want?

## Education

- Expectations of Tenancy, Lease and Housing Options
- Available Resources for Support

## Housing Access/Retention Plans

Using Treatment as a Link to Self-Defined Goals

Linkages and Coordination

Evaluate Progress

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# Expectations of Tenancy

Paying Rent

Maintaining Apartment

Quiet Enjoyment

Occupancy

# Focused Housing Stabilization Planning

Limit the areas of intervention based on housing barriers assessment

Focus on the most pressing needs that impact housing

Relate all interventions to keeping housing + long term goals

Be aware this may not be a linear process

Be mindful about moving from crisis

# Tenants' Goals

A safe place to live

Work

Enough money to live on

Friends

Valued status and a role in the community -  
purpose and structure

A chance for themselves and their children



# Getting to the Housing Plan

Look at person's goal and **importance** of components

Ask for **examples** and **elaboration**

Link housing to identified goal

Look at **competencies** based on history and role

Look at barriers to the goal

- Assess barriers using **stages of change**
- Establish how negotiable some barriers are: such as felony background and subsidies
- Looks at **importance** to person of the behaviors associated with barriers: such as being able to have friends stay

# Components of the Housing Plan -- Goals

- Goals set as a team of clients and worker
  - Focus on the issues that affect housing access and retention - base on what caused previous episodes of housing instability
  - Immediate and longer term goals clear
  - The Plan determines your interventions
  - Steps to reach goal clearly defined and measurable
  - Longer term needs require connections to other resources.
    - *Goals provide structure and purpose*
    - *Allows to move away from acute services*
- 
- *Provides a role for the worker and Veteran*

# Using Resources

## Identifying sustainable resources with clear expectations

Housing: landlord/property managers

Financial: benefits and employment providers

Health/Mental Health: treatment and support

Substance Use: treatment and support

Family and Relationships: support structure

Life Skills: services for assistance/support

# Key Roles – Landlord and Service Provider

Landlord has a key role in helping people understand their obligations and comply with them. (Assertive approach)

- Establish the **expectations** for the tenant

The social services staff provide and arrange for services needed to maintain housing and also function as advocates for the tenant.

- Assist the tenant to meet the **expectations of tenancy**

# Building Skills

Educating on rights and responsibilities

**Modeling** for people to negotiate for services and enlisting the service's/support's help

Trying it out and debrief

Establishing regular check ins to see if it is working

Review cost and benefits - **critical thinking**

**Recognizing** strong partners and good skills

Renegotiate the relationship as necessary

Focus on longer term planning ( non crisis based)

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# Changing Expectations

## Moving from crisis to planning

- May be from immediate to 15 minutes from now

## Critical Thinking

- Using strategies and resources that work best for each person

## Structure and purpose

- Developing a structure and purpose to days that are different from when homeless

## Developing new or changed roles

- From homeless person to tenant, parent, worker, advocate

# Transition Issues

Fear of failing

Lack of skills

Nothing to do

Still maintaining old routine

Declining assistance

Worker role: assertive ongoing engagement

# Eviction Prevention

Educating everyone on rights and responsibilities of tenancy

Regular communication with the landlord to catch any lease violations early

Agreement with the tenant and landlord about working together

Resources to address lease violations ( back rent, clean up)

Knowledge of timelines for the eviction process

Policies on involvement

Eviction/Crisis planning to avoid eviction



# EVIDENCE BASED PRACTICES

# HOUSING FIRST

- everyone deserves a right to housing, especially the chronically homeless
- an person need NOT have all the skills in order to be housed
- housing is primary, services are secondary
- services are wrapped around the individual
- once housed, the services are what is going to help the individual maintain their housing
- Housing First is a harm reduction approach
- housing is the stabilizing force in order to achieve other goals
- 80% retention rates

# CRITICAL TIME INTERVENTION (CTI)

- the critical time is the time of transition (homelessness to housing or prison to housing)
- focuses the intensity at the beginning and tappers off towards the end
- uses a time-limited and narrow focus (no more than 3 areas to work on at a time)
- focuses on both formal and informal networks to build up the individual's support networks
- emphasis on utilizing both formal and informal supports
- care coordination is key
- uses harm reduction, recovery, Motivational Interviewing skills

# Readings & Resources

# READINGS ON “CHRONIC HOMELESSNESS”

- Burt, M. (2005). U.S. approaches to Ending Long-Term Homelessness for People with Disabilities. Prepared for CUHP Final Conference, Brussels, Nov. 3-4.
- Corporation for Supportive Housing: Toolkit for Ending Long-Term Homelessness. 2004.
- Ending Chronic Homelessness Through Employment and Housing: A Leadership Dialogue. January 2006. Chronic Homelessness Employment Technical Assistance Center (CHETA).
- More Than a Place to Live: A special report about supportive housing and its impact on chronically homeless populations. March 2006. Robert Wood Johnson Foundation

# READINGS ON “CHRONIC HOMELESSNESS”

- October 27, 2005. Evidence-Based Practices and Promising Practices for Individuals Who Are Homeless and Have Mental Illnesses. Osher, F. Annual Substance Abuse and Mental Health Services Administration, Washington, D.C.
- Substance Abuse and Mental Health Services Administration Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-Occurring Substance Use Disorders. DHHS Pub. No. SMA-04-3870. 2003
- Williams, F. & Dennis, D. (2002). Preventing Chronic Homelessness: Effective Approaches Emphasize Flexibility & Access.

The Home For Good  
Standards of Excellence

# HOME FOR GOOD STANDARDS OF EXCELLENCE

## What are the standards?

- Set of performance and quality goals for providers
- Developed by and for outreach, emergency shelter and permanent supportive housing providers
- Identify critical outcomes necessary to reduce and end homelessness
- Establish aspirational best practices for providers
- Acknowledge systemic needs



# HOME FOR GOOD STANDARDS OF EXCELLENCE

## What are the goals and purpose of the standards?

- To provide concrete, measurable ways to understand our progress in ending homelessness - for providers, funders, and all system stakeholders
- To ensure efforts & resources are focused as effectively as possible
- To push forward solutions that help end homelessness
- To recognize those who “move the needle” to end homelessness
- To help service providers identify opportunities for capacity-building and create more effective programs

# HOME FOR GOOD STANDARDS OF EXCELLENCE

## What are next steps for Standards?

- Standards work groups complete baselining process and finalize standards
- Steering Committee of stakeholders develops implementation process
- Capacity-building TA and training sessions over the next year, with content based on community feedback on standards
- Current goal is to fully launch standards in Spring of 2014
- Ongoing efforts to recognize success and provide support in areas of challenge

# HOME FOR GOOD STANDARDS OF EXCELLENCE

## How are the standards organized?

- **Performance Goals & Indicators**
  - Benchmarks to quantitatively identify success and progress
- **Operating Standards**
  - Hallmarks of high quality programs
- **Suggested Practices**
  - Strategies and guidance to support performance goals
- **Systems Recommendations**
  - Acknowledge need for systems change and engage systems stakeholders

# HOME FOR GOOD STANDARDS OF EXCELLENCE

Home For Good will continue to engage the community as the Standards of Excellence are implemented.

For more information, and updates on TA and training opportunities,

- go to the session at 3pm today

go to: <http://www.unitedwayla.org/2013/05/announcing-the-home-for-good-standards-of-excellence-seminars/>

# THANK YOU FOR ATTENDING!

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